2010

Massachusetts Department of Revenue

Form MDCA
Medical Device Credit Application

For calendar year 2010 or taxable year beginning **and ending**

Medical device company name | Federal Identification or Social Security number

Mailing address | City/Town | State | Zip

Name of contact person | Telephone | E-mail address

1 Type of medical device company:
☐ Corporation ☐ Trust ☐ Partnership ☐ Sole proprietorship ☐ LLC ☐ Other _____

2 Qualified user fees paid to U.S. Food and Drug Administration during the taxable year. ("Qualified user fees" are "user fees" as defined in TIR 06-22.)
Note: Include only those qualified user fees related to new medical devices or to upgrades, changes or enhancements to existing medical devices, developed or manufactured in Massachusetts. A new medical device or an upgrade, change or enhancement to an existing medical device is "developed or manufactured in Massachusetts" if more than 50% of the development or manufacturing costs associated with the medical device or the upgrade, change or enhancement are incurred in Massachusetts **2**

3 Date(s) of qualified user fee payment(s) _____

4 Address of Massachusetts plant or facility _____

5 Brief description of medical device(s) to which the user fees above relate _____

6 Percentage of development or manufacturing costs incurred in Massachusetts **6**

Note: Attach copies of all USDA Department of Health and Human Services Food and Drug Administration Medical Device User Fee Cover Sheets associated with this application.

I declare under the pains and penalties of perjury that to the best of my knowledge, the information contained herein is accurate and complete.

Signature | Date

Mail to: **Massachusetts Department of Revenue, Audit Division, 200 Arlington Street, Room 4300, Chelsea, MA 02150, attn.: Medical Device Unit.**